Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS667HOS	A. BUILDING _____ B. WING _____	03/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HOSPITAL MEDICAL CENTER	620 SHADOW LANE LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 03/26/10 in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00024533 was substantiated with deficiencies cited. (See Tag S0300). Complaint #NV00024432 was substantiated with deficiencies cited. (See Tag S0160). A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000	A. On 4/19/10 & 4/23/10, the Director of Critical Care Services will provide education to the Emergency Room Nursing Staff related to appropriate monitoring and documentation of discharge disposition , including method of discharge, of patients that have received narcotics during their course of treatment. Focused education and counseling was provided to the care provider that discharged the referenced patient. B. The recognition of others that may be affected will be completed by the treating Emergency Room Nurse and physician C. Procedures and documentation tools are currently in place addressing the process of administration, monitoring and documentation of care and discharge of patients receiving narcotics. These forms and policies were reviewed by the Administrative Director of Quality Outcomes and the Performance Improvement Manger on 4/8/10 for appropriateness (Emergency Room T-Sheet and Patient Discharge Criteria) D. Over the next 3 months, ten (10) Emergency Room charts of patients that have received narcotics and have been discharged from the Emergency Room, will be audited to ensure that appropriate monitoring and	
S 151 SS=D	NAC 449.332 Discharge Planning 9. The evaluation of the needs of a patient relating to discharge planning and the discharge plan for the patient, if any, must be documented in his medical record. This Regulation is not met as evidenced by: Based upon record review and interview, it was determined that the facility did not ensure that an	S 151		

Accepted Corrected 4-20-10

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 4-16-10

STATE FORM 6899 3V8311 If continuation sheet 1 of 3

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S 161	Continued From page 1 the needs of one of three patients were evaluated and documented in the medical record. Specifically, no documentation was found that one patient had been educated not to drive after receiving a narcotic drug (Patient Identifier: 3).	S 161	documentation has been completed by Valley Hospital Medical Center's Quality Director. The information from this audit and educational activities will be reported at the monthly Patient Safety Meetings (May, June and July 2010) and be referred to the monthly Performance Improvement Committee. E. The Director of Critical Care Services and the Patient Safety Committee have the responsibility of ensuring compliance F. Additional training of staff will be completed by 4/28/10. The monitoring and reporting to the Patient Safety Committee will be completed by July 30, 2010.	
S 300 SS=G	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based upon record review and interview, it was determined that the facility did not ensure that treatment was provided based upon the assessment of one of three patients (Patient Identifier: 2). Findings: On 03/26/10, an abbreviated survey was conducted to investigate an allegation that the facility did not treat one of three sampled patients for a foreign body embedded in her foot. Patient 2 was admitted to the facility on 09/27/08 for cellulitis of the foot, a heel and midfoot ulcer, tenosynovitis of the foot and ankle, lung disease, hypertension, and hypercholesterolemia. An x-ray of the right foot was ordered to "R/O (rule out) a FB (foreign body)". At 09/27/09 at 6:41 AM, three view x-ray was performed. The findings indicated that "On the	S 300	A. The diagnostic films, which assisted in making the decision to discharge the patient, were reviewed by the Chief of Radiology with any finding referred to the Medical Staff Department for peer review purposes. Additionally, ongoing surveillance of interpretation discrepancies will be monitored and reported to the Medical Staff Department. B. The recognition of others that may be affected will be completed by the treating physician.	

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S 300	Continued From page 2 lateral film only I see a triangular density ventral to the toes. This is probably ventral to the 4th MTP joint. This could represent a glass shard. It is odd that I only see it only one view (sic)". The impression in the report stated, "Possible 7 mm x 2 mm triangular foreign body just ventral to the 4th MTP joint but I only see this on one view". The Discharge Summary stated "On the 3-view foot x-ray, and there was a triangular foreign body just ventral to the 4th MTP joint was only seen on 1 view however. It was not reseen on the MRI of the right foot...". Patient 2 was then discharged. She was admitted to another facility in December for a continued infection in her foot. A right foot MRI dated 12/04/08 stated under "Impression", "Probable 6 mm in size foreign body within the plantar soft tissues at this level". Patient 2 subsequently underwent surgery for the removal of this foreign body at another facility. Her Discharge Summary from that facility, dated 12/08/08, stated, "The patient had lower extremity foot osteomyelitis. The patient had a glass foreign body removed...". Based upon the findings of this investigation, the allegation was substantiated.	S 300	C. Currently, Valley Hospital Medical Center's policies and practice guidelines address situations wherein a foreign body is difficult to visualize or is questioned on a film. These processes were followed with the foreign body still eluding detection. Consequently, the case is being referred to the Chief of Radiology and the Peer Review Process for additional findings and corrective actions, as warranted. D. Five (5) radiological studies, with interpretations completed by the physician in question, will be over-read by the Chief of Radiology to ensure on-going accuracy. Discrepancies will be reported to the Medical Staff Department to be utilized in the re-credentialing process E. The Chief of Radiology, Medical Staff and the Patient Safety Committee have the responsibility of ensuring compliance. F. Referral to the Chief of Radiology and subsequent Medical Staff Department, for peer review, to be completed by May 1, 2010.	